Center for Mindful Development, PLLC
Psychological Services and Mindfulness Education
109 B Millstone Drive
Hillsborough, NC 27278
(919) 370-0770
http://www.mindfuldevelopment.com

Questionnaire for Parents or Guardians of Client

Instructions: Please answer the questions below as completely as you can. If you do not have all of the information, please let me know. If you have any questions about the content of the questionnaire or its uses, please ask. The information you provide will assist me in providing the best evaluation or treatment for you and/or your family member. Thank you!

General Information

Today's date: ________________________ Referred by: ____

Or, how did you hear about the Center for Mindful Development or Dr. Caroline Hexdall?

____

Name of person(s) completing this form and relationship to client (mother, father, guardian, etc.):

____

Client (Child or Adolescent) Name: ____________________________________ Date of Birth: ______________________

Family Information:

With whom does your child live? ___ Biological parents ___ Adoptive parents ___ Biological and Step-parents

___ Grandparents ____ Foster parents or Other: ____

Mother's/Father's name: ________________________________ Highest education completed: ____________________

Occupation: __________________________________ Present Marital Status: __________________________________

Complete home address: ____

Phone Numbers (please provide the number and circle yes or no if I can leave a message):

_________________(work) Yes No ________________ (home) Yes No _________________ (cell) Yes No

Email address: ____ What is the best way to reach you? _______________

Mother's/Father's name: _________________________________Highest education completed: ____________________

Occupation: __________________________________ Present Marital Status: __________________________________

Complete home address: ____

Phone Numbers (please provide the number and circle yes or no if I can leave a message):

________________(work) Yes No ________________ (home) Yes No ________________ (cell) Yes No

Email address: ______________________________________ What is the best way to reach you? ______________

***Client (Child or Adolescent)* Information: Developmental and Family History and Current Health**

Weeks gestation (or indicate full-term): ___________ Briefly describe the pregnancy and delivery, noting any

complications: ____

____

____

Early Milestones – Please indicate approximate ages when your child accomplished these milestones

Social smile: __________ Rolling over: _________ Sitting: _________ Crawling: ___________

Walking: __________ Said first word (age): _________, two words: _________, sentences: __________

Were you ever concerned about your child not meeting developmental milestones? Explain briefly. ___________

____

Family History – Are there any other family members who have struggled developmentally or educationally?
Please describe: ____

____

For each condition listed below, please mark if your child or any close relative (mother, father, grandparents, siblings, aunts or uncles or first cousins) has or has had the condition. If there is no family history for the condition, do not check the "YES" box.

Condition	**YES**	**Relationship to Child**
Addiction (Alcohol, Drugs, Gambling, etc.)		
Allergies (explain:)		
Anger management problems		
Anxiety		
Attention problems		
Autism spectrum disorders		
Bipolar disorder (sometimes called manic depressive)		
Birth defects		
Depression		
Developmental disabilities		
High blood pressure		
Hyperactivity/Impulsivity		
Intellectual disability (formerly called mental retardation)		
Learning problems or learning disabilities		
Migraine		
Mental illness		
Oppositional behavior		

Seizure disorder		
Sensory processing issues		
Speech or language delays		
Suicide/Suicide attempt		
Tic Disorder		
Other:		
Other:		

Does your child take prescribed medications or vitamins/supplements? ____________________________________

Current diagnoses (if applicable): ____

Has your child ever been hospitalized or had surgery? ______ Yes ______ No If so, please explain.

____

When was your child's last hearing evaluation or screening? ________________ (Date) What were the results?

____

When was your child's last vision evaluation or screening? _________________ (Date) What were the results?

____

Other professional providers (e.g., primary care physician, occupational, physical or speech language therapist, psychiatrist):

Name and/or Name of Practice *Date(s) of Service* *Comments*

_____________________________ ________________ ____

_____________________________ ________________ ____

Describe your child's sleep routine (including times, location, activities associated with sleep, # of hours he or she sleeps on average, routine for waking up, etc.)

____

____

Describe your child's eating preferences (including preferred and non-preferred foods, mealtime behaviors, etc.)

____

____

Client (Child or Adolescent) Information: School

Current school or day care: ____ Grade: _____________________

Teacher (Lead or primary): _________________________________ Does your child's school use Responsiveness to Instruction (RtI)? ________________ Is your child currently receiving special education services? ___________

If so, please answer the following to the best of your knowledge (you may also provide your child's IEP):

Category of eligibility ____

Related services your child receives at school (e.g., speech therapy, occupational therapy, physical therapy, etc.) ____

Previous child care settings or school settings (please provide past school history indicating whether your child repeated a grade, skipped a grade, received special education services, etc.):

School	*Age when attended*	*Comments*

Client Information: Home

Please provide information about all other persons living in the household with the client

Name	*Age*	*Relationship to your child*	*Comments*

Please provide information about other people who care for your child for a significant amount of time.

Name	*Relationship to your child*

What are some of your child's preferred activities at home (other than watching television): __________________

____

Approximately how much time each day does your child spend doing the following activities:

____________ playing outside _____________ watching TV ______________ using the iPad or other tablet device

____________ using a cell phone ___________ reading/looking at books ___________ playing video/computer games

____________ imaginary play ___________ board games _________ computer (use for other than games)

_______________________________________ other (describe)

When your child plays, is it mostly solitary play, mostly with someone (friend or sibling) or both? ______________

____

Parenting Information – Discipline

Who generally disciplines your child (mother, father or both): ____

What techniques or strategies are used for inappropriate/undesired behavior: ______________________________

____

What techniques or strategies are used for appropriate/desired behavior: __________________________________

____

Describe how effective these strategies are or are not: ____

____

____

Is discipline an area where you would like assistance? ____

Strengths and positive characteristics of your child

Describe your child in 2-3 sentences, focusing on the positive and what you love most about him or her. ________

____

____

When was the last time you had a really joyful, good day or time with your child? Describe this day. ____________

____

____

How do you show your child you love him/her? ____

____

How does your child show you he or she loves you or enjoys spending time with you? _________________________

____

How do you know when your child is happy? ____

What is your child proud of? ____

What are you most proud of with regard to your child? ____

Present Concerns

What has you concerned about your child's development, learning or behavior? ______________________________

___

___

___

If you listed more than 3 concerns, what are the two issues that have you most concerned? ___________________

___

___

___

___

When did you notice these concerns developing? ____

___

___

What have you been told by doctors, teachers and/or other professionals about your child's struggles? _________

___

___

___

What are your expectations from this evaluation or therapy or what specific questions do you want to have answered? ____

___

___

Is there anything else you would like for me to know about your child or your family that you think would be important to your child's evaluation or therapy? ____

___

Thank you for taking the time to complete this questionnaire. I look forward to working with you and your child.